All referrals to Day Hospital are now processed by the Referral Information Centre. Please fax this form to:
Fax No. 4924 2502 – DO NOT POST
Phone: 4924 2590 for verbal referrals

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
DATE OF BIRTH	M.O.

RANKIN PARK DAY HOSPITAL REFERRAL FORM - REHABILITATION / FALLS

Discharge JHH65D

HNE022900

RPDH
Consultant's Name: _____ (Ring 4985 5750 for appropriate Consultant's name)

Please attach / fax:
*list of medications Yes ☐
*background history Yes ☐
*copy of recent pathology results Yes ☐ N/A ☐
*discharge summary if discharged from hospital Yes ☐ N/A ☐

IF THIS PATIENT IS PRONE TO FALLS, PLEASE COMPLETE REQUIRED INFORMATION OVERLEAF

Patient's phone: _____ Contact person to make appointment - Person responsible ☐ Patient ☐

Person responsible: _____ Relationship: _____ Phone: _____

Address: _____

Does patient live alone? Yes ☐ No ☐

If NO, with whom does the patient live? _____

Is an interpreter required? ***No*** ☐ ***Yes*** ☐ ***If yes Language spoken:*** _____

Is the carer able to transport the patient? Yes ☐ No ☐

Local GP: _____ Phone: _____

Is the GP aware of the referral? Yes ☐ No ☐

Primary Diagnosis: _____

Reason for the referral / goals: _____

Services organised: _____

Equipment at home: _____

Other relevant information: _____

Priority: **Yes** ☐ **No** ☐

Person referring (print name): _____ Provider No if applicable: _____

Designation: _____ Signature: _____

Address: _____

Phone: _____ Fax: _____ Date: _____

BINDING MARGIN – DO NOT WRITE

271011

REFERRAL FORM - REHABILITATION / FALLS

Discharge

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HOSPITAL / WARD:

COMPLETE FALLS RISK HISTORY

Please complete front and back page

Falls History:

_____

_____

_____

_____

_____

_____

Type / Amount in last 12 months: _____

Falls: Slip ☐ Trip ☐ Dizziness / Syncope ☐ Other type of fall _____

Risk: High ☐ Medium ☐ Low ☐

Other relevant information:

_____

_____

_____

_____

_____

QUICK SCREEN SCORE (if applicable): _____

MMSE: _____ Walking aid: Stick ☐ Frame ☐ Nil ☐ Other ☐

Person referring (print name): _____ Provider No. if applicable _____

Designation: _____ Signature: _____

Address: _____

Phone: _____ Mobile: _____ Fax: _____ Date: _____

BINDING MARGIN – DO NOT WRITE

271011